Appendix E Point of Service Health Plan Effective 1/1/09***

19.8.	**Appendix E**	
BENEFIT HIGHLIGHTS	**Point of Service In-network Benefits**	**Point of Service Out-of-network Benefits**
Primary Care Physician (PCP) Office Visit:		
Preventive Care for children and adults	**No charge**	**80% Coinsurance***
Immunizations	**No charge**	**No charge**
Medical Care for Illness or Injury	**$10 Co-pay per visit**	**80% Coinsurance***
Surgery Performed in the Physician's Office	**$10 Co-pay per visit**	**80% Coinsurance***
Routine Mammograms, PSA, Pap Test	**No charge**	**No charge**
Specialty Physician Office Visit:		
Office Visits: Consultant and Referral Physician Services	**$20 Co-pay per visit**	**80% Coinsurance***
Allergy Treatment/Injections	**$10 Co-pay per visit**	**80% Coinsurance***
Surgery Performed in the Physician's Office	**$20 Co-pay per visit**	**80% Coinsurance***
Inpatient Hospital Services –		
Includes Semi-Private Room and Board	**No charge**	**80% Coinsurance***
Diagnostic/Therapeutic Lab and X-ray		
Inpatient Hospital Doctor's Visits/Consultations		
Outpatient Facility Services:		
Operating and Recovery Room	**No charge**	**80% Coinsurance***
Diagnostic/Therapeutic Lab and X-ray	**No charge**	**80% Coinsurance***
Physician & Outpatient Professional Services	**No charge**	**80% Coinsurance***
Laboratory and Radiology Services:		
MRIs, CAT Scans and PET Scans	**No charge**	**80% Coinsurance***
Other Laboratory and Radiology Services		
Outpatient Hospital Facility	**No charge**	**80% Coinsurance***
Independent X-Ray and/or Lab Facility	**No charge**	**80% Coinsurance***
Short-Term Rehabilitative Therapy (includes cardiac rehab, physical, speech and occupational therapy)	**$10 Co-pay per visit**	**80% Coinsurance* up to $3,000 per calendar year for all therapies combined**
Chiropractic Services 20 visits maximum per calendar year	**$10 Co-pay per visit**	**80% Coinsurance***
Prescription Drugs		
Retail (per 31 day supply):		
Generic drugs	**$5 Co-pay**	**N/A**
Formulary brand drugs	**$10 Co-pay**	
Non-formulary drugs	**$15 Co-pay**	
Mail Order Drug: generic, formulary brand, or non-formulary (per 90 day supply)	**2 x the applicable 31 day Co-pay**	
Emergency and Urgent Care Services:		
Physician's Office – PCP or Specialty Physician	**$10 per visit to PCP, $20 per visit to Specialty Physician**	**$10 per visit to PCP, $20 per visit to Specialty Physician**
Hospital Emergency Room/Urgent Care Facility	**$50 Co-pay per visit (co-pay waived if admitted)**	**$50 Co-pay per visit (co-pay waived if admitted)**
Ambulance	**No charge**	**No charge**
Inpatient Services at Other Health Care Facilities	**No charge**	**80% Coinsurance***
Skilled Nursing, Rehabilitation and Sub-Acute Facilities	**30 days combined maximum per calendar year**	**30 days combined maximum per calendar year**
Maternity Care Services:		
Initial Office Visit to Confirm Pregnancy	**$10 Co-pay**	**80% Coinsurance***
All other office visits	**No Charge**	**80% Coinsurance***
Delivery		
Hospital Charges	**No charge**	**80% Coinsurance***
Physician Charges	**No charge**	**80% Coinsurance***
Home Health Services	**No charge**	**80% Coinsurance***
Hospice Care Services	**No charge**	**80% Coinsurance***
Family Planning Services		
Office Visits (tests, counseling)	**$20 Co-pay per visit**	**80% Coinsurance***
Vasectomy/Tubal Ligation (excludes reversals)	**$20 Co-pay**	**80% Coinsurance***

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BENEFIT HIGHLIGHTS	Point of Service In-network Benefits	Point of Service Out-of-network Benefits
Infertility Services:		
Office Visit (Tests, Counseling)	**$20 Co-pay per visit**	**80% Coinsurance***
Hospital Charges	**No charge**	**80% Coinsurance***
Coverage will be provided for the following services:		
Testing and treatment services performed in connection with an underlying medical condition.	**No charge**	**80% Coinsurance**
Testing performed specifically to determine the cause of infertility.	**No charge**	**80% Coinsurance**
Treatment and/or procedures performed specifically to restore fertility	**No charge**	**80% Coinsurance**
Artificial Insemination	**No charge**	**80% Coinsurance**
TMJ - Surgical and Non-Surgical – case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office	**$20 Co-pay per visit**	**80% Coinsurance***
Hospital Charges	**No charge**	**80% Coinsurance***
Mental Health Services:		
Inpatient	**No charge**	**80% Coinsurance***
Outpatient	**$10 Co-pay per visit**	**80% Coinsurance***
Substance Abuse Services	**Inpatient – No charge limited to $5,000 per calendar year Outpatient $10 Co-pay per visit limited to $5,000 per calendar year**	**Inpatient/Outpatient 80% Coinsurance*/ 80% Coinsurance* both limited to $5,000 per calendar year**
Durable Medical Equipment/External Prosthetic Appliances	**No charge**	**$100 per member deductible then 80% * Coinsurance**
Vision Care		
Eye exam	**$10 Co-pay per visit**	**80% Coinsurance***
Exam Frequency		
Under age 19 – limited to one exam every calendar year	**One exam every calendar year**	
Age 19 and over – limited to one exam every two calendar years	**One exam every two calendar years**	
Hardware		
Health Club/Equipment Reimbursement **NOTE: This is a Taxable Benefit**	**N/A**	**N/A**
Annual Deductible		
Individual	**None**	**$150**
Family	**None**	**$400**
Annual Out-of-Pocket Maximum (OOPM) for Prescription Drugs		
Individual		
Family	**$500** **$1,000**	**N/A**
Annual Out-of-Pocket Maximum (OOPM) for covered medical costs**		
Individual		
Family	**$ 500** **$1,000**	**$1,500** **$3,000**
Lifetime Maximum	**None**	**None**

***Deductibles apply **Credits toward the in-network OOPM accrue separately from credits toward the out-of- network OOPM**
*****Current plan design (as of 6/30/07) remains in effect until 1/1/09. The co-pays referenced herein become effective 1/1/09.**
Benefit Maximums apply to in-network and out-of-network combined.
All out of network services limited to reasonable & customary limitations

Benefit Exclusions:

Your plan provides coverage for medically necessary services only.